decontaminated and the application of substances such as soaps, creams and ointments which may be contaminated with bacteria.

The length of these comments should not be construed as reflecting the breadth of the problem, but rather the continuing uncertainty about optimal methods for prevention and management of Gram-negative bacillary bacteremia. Perhaps with further clinical investigation, particularly in the areas of prevention through modification of the host[4,5] or the environment, a future editorial may be as brief as "veni, vidi, vici."

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Informed Consent in Focus

THE LEGAL CONCEPT of "informed consent" has been thrust upon the medical profession rather precipitously and, for many physicians, without warning. To act and react intelligently and in the best interest of both patient and physician, several vital points need to be in focus.

1. "Informed consent" did not develop in a vacuum. For at least a decade in the United States and elsewhere the protection of the individual against the giants of mechanized and computerized society has been promoted, developed and imposed upon all. This protection, under the general label of "consumerism," manifests itself in many ways. Essentially, it is a revolt against mass advertising, mass production, mass distribution, mass everything. It has taken root and it is flowering. It has been said that consumerism is a magic word in contemporary society.

A basic concept of consumerism is that every individual has a "right to know" and a right to make his own decision, uncoerced by television or any other overpowering, brain-washing technique. The legal doctrine of informed consent is one among hundreds of manifestations of the concept of the right to know and to make one's own decisions, good, bad or indifferent. To understand what the courts are saying on informed consent, one must relate the concept to the whole —the whole being protection of the individual.

2. While the legal requirement of informed consent in medicine is stated in terms of telling the patient about risks and alternates, there is nothing in the law or in the concept of informed consent that mandates presentation of a negative or fear-provoking approach to the patient. In *Cobbs vs. Grant* the California Supreme Court held that a legally valid consent requires that the physician convey all information necessary for the patient to make a knowledgeable decision. Although to date cases before courts have involved issues that have resulted in an emphasis on the negative aspects of the "tell it like it is" rule, the patient's right to know includes all essential information; in other words, the positive as well as the negative, the benefits as well as the risks. Therefore, in approaching application and implementation of informed consent on a real life physician-patient basis, it would appear essential for the physician to give equal billing to the benefits of a procedure—to the good that it may do and the reasons it is recommended.

3. There is nothing new in the requirement of consent to any procedure that involves bodily contact. Without consent, any bodily contact that involves possibility of harm is an assault or battery. Hence, consent, express or implied, has always been necessary to elective surgical procedures and to other procedures involving bodily contact. The newness is in the word "informed." The concept that the patient has a right to know, coupled with a right to make his own decision on the basis of knowledge, is the new development. This, however, changes traditional concepts. No longer does a printed form suffice. It neither implies nor proves that the signer had any information whatsoever. No longer can the task of obtaining consent be routinely delegated to aides and assistants. In *Cobbs vs. Grant* the California Supreme Court made it very clear that informing the patient is the duty of the physician. Consent without adequate information on which to form a judgment is no longer legally sufficient. The Court also said a patient may decline information. This is fine if

the decision and the expressed wish not to be informed originate solely with the patient, but is a slender reed indeed if suggested or stimulated in any way by the physician.

4. What should the physician do now to obtain a legally sufficient consent? First, he must develop methods suitable to him and his practice to acquaint patients with the benefits, risks and alternates to procedures that involve bodily contact, hence requiring consent. Any method that will achieve the legally required objective is acceptable. The use of specially prepared booklets or monographs can be a desirable tool in many instances. In other situations perhaps spoken communication will be the most satisfactory. The task of "informing" does not lend itself to mass production. In addition to developing information techniques, the physician needs to understand what will give him the most protection in a court of law. First, the signature of the patient on any paper is not necessarily helpful. Signature on an explanatory document that is written in plain English, is of some help; signature on a complicated instrument, cast in stilted medical or legal terms, is most likely useless and possibly harmful. Probably the most helpful to the physician is his own entry in his record of the patient, entered as soon as possible after making the explanation and securing consent. The entry should briefly summarize the discussion with the patient and identify the patient's basic responses. As a "record made in the ordinary course of business," it is entitled to great weight.

5. Why bother with an "informed consent"? Clearly, if the medical management of a patient results in a satisfactory conclusion, the presence or absence of an informed consent is highly unlikely to surface. On the other hand, if a bad result occurs, the absence of an "informed consent" can be the ground on which a malpractice suit is constructed, even though the medical or surgical care furnished was of top quality and in nowise negligent. The real impact of the doctrine of informed consent on the practicing physician is that it creates a new and additional framework for a malpractice suit. Total absence of consent has always been the ground for an assault and battery complaint; but now a consent obtained, but without adequately informing the patient, though it may protect against an assault and battery suit, will not protect against a suit based on lack of "informed" consent.

The requirement of informed consent is not all bad. Various studies have demonstrated that the patient who refuses risky surgery when the risks are explained is also quite likely to be the suit-prone patient. So perhaps implementation of the informed consent concept may prevent some malpractice suits that would otherwise have occurred. Be that as it may, one thing is certain and that is that the plaintiff's lawyers will allege lack of informed consent as a routine matter in future malpractice suits.

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From "Crisis" to Chaos to What?

THE FLAMES of what has been officially declared a "crisis" in health care have been burning more or less out of control for more than a decade. Each effort to contain or extinguish them seems to end up by just adding more fuel to the fires. It is worth remembering that this has been for the most part a government-determined and government-declared "crisis," and it is worth noting that wave after wave of government plans and programs have done little to improve things and more often seem to have made them worse. There is much to suggest that, if present trends continue, what so far has been merely a "crisis" may soon become some sort of chaos.

Of late there seems to have been less talk of crisis and more evidence of chaos. The problems of the health care crisis reflect many of the unsolved problems of government and society generally. There seems to be a growing resistance to regulation or control by government or by any outside authority, possibly because these simply are not working well in today's society. The "crisis" in health care began by focusing particular attention on health care and longevity, and those in government who were assigned to deal with this crisis seem to have assumed that, if enough money were available and properly allocated, health and long life could become the right of every American.

The miscalculations were little short of monumental. The infusion of money produced rising costs in patient care which largely negated the